FOR HEALTH PLAN USE ONLY – THIS FORM IS **NOT** AN APPLICATION FOR INDEPENDENT MEDICAL REVIEW

HEALTH PLAN CASE SUBMISSION FORM

	Plan Notification Date	Timing for Submission	
CA CASE # _____	_____	Expedited Review _____ (24 hrs_____)	Standard Review _____ (3 days_____)

1. REVIEW TYPE:

Urgent Care/Emergency Services _____ Medical Necessity _____ Experimental/Investigational _____

2. **HEALTH PLAN INFORMATION:**

Name of Health Plan: _____
Trade Name (if different): _____
Insurance Product Name: _____
Contact Name (for IMR): _____
Contact Title: _____
Department: _____
Street Address: _____
City, State, Zip: _____
Phone Number: _____
Fax and E-Mail Numbers: _____
Alternative Contact:
Name _____
Phone _____

NETWORK/DELIVERY MODEL:

_____Group Managed Care _____ PPO
_____ IPA or Mixed Network _____ Indemnity
_____ Point of Service _____ Other

Is member restricted to a:

PCP: Yes ____ No ____
Name: _____

Medical Group: Yes ___ No ___
Name: _____

3. PATIENT/SUBSCRIBER INFORMATION:

Name: _____
Age: _____ Gender: _____ Membership ID#: _____
Relationship to Member: _____
(If patient is a dependent or covered under another person's contract, identify the subscriber)
Subscriber Name: _____ Membership ID#: _____

Address Information for CHDR contact with the member or subscriber: (for correspondence regarding case.)

Contact Name: _____
Contact Address: _____
Contact City/State/Zip: _____
Contact Phone: Work: _____
Home: _____

4. DEFINITION OF MEDICAL PROVIDERS REFERENCED IN THE REVIEW:

Complete this section to identify only those providers directly involved in the disputed case.

Type of Provider	Names	Type of Specialty	In-Plan (Y) or (N)
PCP:			
Referring M.D.:			
Specialist:			

Others: _____

5. DEFINITION OF DISPUTED (DENIED) CARE AND NATURE/SCOPE OF DENIAL DECISION:

History relevant to disputed care and clinical rationale for services that Health Plan is or is not proposing to cover (including treatment alternatives). If denial is "partial", define component or scope plan is authorizing vs. denying.

_____

_____

_____

_____

_____

_____

_____

_____

PRIMARY DIAGNOSIS RELATED TO CASE: **DIAGNOSIS CODE (if applicable):**

_____ _____

Disputed Care Procedure Name: **Code (if applies):**

_____ _____

Medical Necessity Decision Applies: Yes: _____ No: _____
Coverage or Benefit Decision Applies: Yes: _____ No: _____

Check all that are applicable:

A) Prior Authorization Denial _____ Retrospective Denial _____ Both _____

B) Total Denial _____ Partial Denial _____ Proposed Modification to Service _____ Delayed _____

C) Reduction of Ongoing Care _____ Termination of Care _____

D) Approved Service, but will Not Approve Site/Provider Sought by Patient _____

Initial Decision Date:	Medical Reviewer's Name:	Specialty Board:	Employed by:
_____	_____	_____	_____
Appeal Date:	Medical Reviewer/Committee:	Specialty Board:	Employed by:
_____	_____	_____	_____

Did any Provider (Plan or Non-Plan) Support or Submit a Referral for the Member's Request for the Denied Service?

Yes _____ (Please attach any documents or citations submitted for review by provider).

No _____

Any evidence Cited/Criteria Cited by the Health Plan in Development of its Denial should be included for review (including relevant literature, technical assessments, etc.)

6. ADDITIONAL INFORMATION FOR A COMPLETE PLAN CASE FILE:

The following documentation is considered mandatory to resolve the disputed health care services:
(Check below all items submitted with this form.)

- ❑ Is the disputed treatment being offered in the context of a recognized clinical trial Yes _____ No _____
  If yes, please provide treatment protocol and records pertaining to patient's trial assessment and enrollment.
- ❑ The complete Evidence of Coverage and applicable riders related to any benefit exclusions including formulary and formulary exception policy for pharmacy related disputes.
- ❑ Initial determination and grievance notices sent to the subscriber.
- ❑ Complete copies, with attachments of referral or claim forms.
- ❑ Relevant correspondence from the provider, subscriber or representative who support the disputed service. Include medical evidence or citations.
- ❑ All available medical records (all sections, notes, reports, etc.) that are directly pertinent to evaluation of the disputed item, whether from Plan or non Plan providers. If an x-ray, image or lab report is pertinent to the case, include it (as opposed to the consulting physician's narrative report only).
- ❑ Please explain if medical records were requested, but are not available.
- ❑ Any other relevant information in Plan's possession.
- ❑ Inventory of medical records provided by health plan, physician, or enrollee.
- ❑ Is the Plan awaiting results of any relevant tests, consults, etc. Yes _____ No _____
  If yes, please define:

_____

_____

_____

_____

_____

Send Completed <u>Form With Documents</u> to Review Organization:

Please submit the following number of medical record copies:
Medical Necessity IMRs = 2 copies
Experimental/Investigational IMRs= 4 copies

CHDR/Maximus
Attn: Thomas Naughton
3130 Kilgore Road, Suite 100
Rancho Cordova, CA 95670

Send Copy of <u>Form Only</u> to DMHC and Enrollee:

Department of Managed Health Care
HMO Help Center, IMR Unit
980 Ninth Street, Suite 500
Sacramento, CA 95814

CENTER FOR HEALTH DISPUTE RESOLUTION

INSTRUCTIONS FOR COMPLETION:

CALIFORNIA INDEPENDENT MEDICAL REVIEW (IMR)
HEALTH PLAN CASE SUBMISSION FORM

Version 1
March 15, 2001

A. PURPOSE

The Center for Health Dispute Resolution (CHDR) is under contract with the California Department of Managed Health Care (DMHC) to provide independent medical review (IMR) pursuant to Sections 1374.30 through 1374.36 of the California Health and Safety Code. Per this Code, and instructions of the DMHC, an enrollee or valid representative will file an application for an IMR directly to the DMHC. The DMHC is responsible for determining whether the application qualifies for IMR and for issuing notification to the enrollee, the enrollee's physician and the health plan.

If the DMHC determines the application qualifies, it may refer the case for IMR to CHDR. The notification to the health plan by DMHC that a case qualifies, and has been referred to CHDR, triggers a health plan obligation to submit case file information to CHDR, as follows:

TIME STANDARD FOR HEALTH PLAN CASE SUBMISSION TO CHDR

Expedited Medical Necessity Case	Expedited Experimental Case	Standard Case
WITHIN 24 HOURS OF NOTICE	**WITHIN 24 HOURS OF NOTICE**	**WITHIN 3 BUSINESS DAYS OF NOTICE**

The CHDR *Health Plan Case Submission Form* structures the information which health plans are to include in case files sent to CHDR. This form is to be used for all three case types (expedited medical necessity, expedited experimental/investigational and standard medical necessity and experimental/investigational cases).

The form and these instructions will be made available in electronic form on the DMHC Web Site, www.dmhc.ca.gov and the CHDR Web Site, www.healthappeal.com.

B. FORM COMPLETION--GENERAL

The CHDR *Health Plan Case Submission Form* has 6 sections. Sections 1 to 5 collect specified data or text in a "fill in the blank" format. Section 6 of the form is a list of 10 categories of documents (e.g., medical records). The health plan is required to attach complete and legible copies of these documents to the case file. Documents in categories 1 to 6 are mandatory.

A health plan may develop its own version of the first 5 sections of the form (e.g., a word processing template). The health plan may "pre-print" recurring data (e.g., health plan organization information), modify type fonts, or alter spacing or page breaks. However, The health plan must retain all sections and data fields in the order contained on the model form.

CHDR strongly recommends that the health plan type all information entered to the first 5 sections of the form. However, legible handwriting will be accepted.

C. IMPACT OF MISSING OR INCOMPLETE DATA

CHDR understands that the *Health Plan Submission Form* is lengthy and requires information that the health plan might regard as unnecessary. However, we are asking for this information because we have found that it is necessary for the complete and impartial processing of independent medical reviews. Completion of the form, and submission of attachments, will minimize requests for additional information (see Section F, below) and permit CHDR to complete cases on a timely basis.

Please understand that *CHDR is under no obligation to use the "additional information" process to correct health plan case file deficiencies.* If the health plan initial case file is incomplete, CHDR may find that the health plan has failed to justify its denial.

D. CASE DELIVERY AND PACKAGING

CHDR's main office is located in Pittsford, New York. However, CHDR has established a California office specifically for the California Independent Medical Review Program. All correspondence submitted to CHDR pursuant to the State of California, DMHC Independent Medical Review Program should be addressed to[1]:

Center for Health Dispute Resolution
California IMR Program
CHDR/Maximus
Attn: Thomas Naughton
3130 Kilgore Road, Suite 100
Rancho Cordova, CA 95670

Phone Within California: 800 470-4075
Out of California or local: 916 364-8146
FAX 916 364-8134

The CHDR California office phone will be answered during standard business hours. After hours, or in the event of a staff emergency, the phone system will automatically route the call to a private medical answering service. The service will contact on-call CHDR personnel, who will return the call promptly. In the event of a disruption in service in the California office, the health plan may contact CHDR's main office in Pittsford, New York at 716-586-1770. Please identify the call as related to the California IMR Program.

Please note that CHDR does not accept standard cases by FAX, in order to protect confidential patient information from accidental delivery to an incorrect FAX station. Cases should be submitted by US Postal Service or private delivery service to the above address. In the event of an "expedited" case that is due for delivery to CHDR during a non work day, contact CHDR by phone, if possible on the prior (work) day. CHDR staff can be made available to receive a case on the weekend or a holiday, if such prior arrangements are made.

If the health of the enrollee would be compromised because of the time required for hard copy case delivery to CHDR, CHDR will accept an expedited case by FAX. CHDR encourages the health plan to redact confidential data in such FAX transmission. CHDR will not be responsible for the disclosure of confidential data due to incorrect or faulty FAX transmissions.

For hard copy case delivery, place each case in a separate envelope. Do not include information pertaining to two or more cases in the same envelope. It is acceptable for the health plan to include multiple cases in a single delivery package, provided each case is placed in a separate and clearly marked envelope.

We recommend that lengthy case file contents be placed in a single package. If this is not possible, put a cover sheet in each package that acknowledges and "cross references" the other package(s). To protect confidentiality, we recommend packaging in sturdy boxes or rip proof envelopes. CHDR often receives case file envelopes that have been ripped or damaged in transit.

Under the California IMR Program, CHDR is not obligated to send an acknowledgment that it has received a case file from the health plan. A representative of the health plan should call the CHDR California office to confirm our receipt of both initial case files and additional information requests.

CHDR will inform the DMHC, via the DMHC case tracking data system, upon CHDR's receipt of the health plan case file. If CHDR does not receive and does not report (initial) case file receipt within the timeframes established by the DMHC (See Section A, above), the health plan's non-compliance will be forwarded to and tracked by the DMHC.

Please note that because experimental and investigational cases require a panel of three (3) reviewers, four (4) complete copies of the case file should be submitted to CHDR.

Information submitted to CHDR, including imaging studies, will not be returned to the health plans. **Do not** *submit original documents to CHDR. Do submit legible and useful copies.*

[1] Only California IMR cases should be submitted to this address. Medicare Reconsiderations and other cases unrelated to the California DMHC program should be submitted to other CHDR offices following standard procedure.

E. FORM COMPLETION INSTRUCTIONS

1. Review Type

Enter the *case number* provided in the DMHC case acceptance notice to the upper left of the form, page 1, under "*CA Case #.*" Check the field for "*Expedited Appeal*" or "*Standard Appeal*", as applicable. Check the appropriate case type (urgent, etc.) Note that if the case is marked "experimental or investigational" it is automatically scheduled for 21-day processing. Expedited experimental/investigational cases are automatically scheduled for 7-day processing.

In unusual circumstances the enrollee's health may be at risk if CHDR uses the full amount of time available based upon the case classification and related time frames. If there is a requirement for processing the case more rapidly, clearly note the case file in Section 1.

2. Health Plan Information

CHDR requests each of the health plan's *legal name, trade name and insurance product name* to avoid any confusion in organization or insurance product references in the case file. Please provide each name, if it exists.

The Organization Contact person and related contact information will be used by CHDR for all inquiries and correspondence for the submitted case. It is vital that this information is correct for the case at hand.

CHDR understands that the health plan may have provided the DMHC with an "independent medical review" contact person and contact information. If this person, and their contact information as provided to the DMHC is correct for the case at hand, the health plan may enter only the *Organization Person Contact Name.* However, we recommend as a safeguard that the health plan complete the entire section. If another person is the point of contact for the current case, enter that person's name and information.

The entry of an *Alternative Contact Person* is mandatory. This should be an individual who can either reliably address questions about the case, or who can relay questions on a timely basis to the primary contact person.

Please use direct dial phone numbers or provide extensions if available. CHDR would prefer not to be routed to general customer service numbers.

CHDR will utilize email for health plan contacts, provided the email text to or from CHDR does not include confidential data. CHDR will not at this time accept case file submission or attachments to the case file via email.

3. Patient/Subscriber Information

In addition to providing data by which CHDR can verify the case (vs. DMHC case number), this section identifies the individual to whom CHDR should send "enrollee" correspondence.

4. Definition of Medical Providers Referenced in the Review

Case file narrative and medical records typically refer to institutions or physicians by name, but often do not clearly establish the role or relationship of the provider to the health plan or patient. Please review *the entire* case file. List each provider and type or specialty directly involved in the case and enter the relationship codes. If this information does not provide a clear picture of the providers, enter or attach a description. This information can save troublesome and unnecessary inquiries from CHDR.

5. Definition of Disputed (Denied) Care and Nature/Scope of Denial Decision

Provide a brief description of the enrollee's medical history and current condition, with emphasis on the major clinical facts relevant to the dispute. In some cases, the dispute regarding treatment may be related to a dispute about diagnosis. Be certain to indicate any such disagreements. Complete diagnosis name(s) and code(s) are required.

Clearly define the disputed or denied service. Clarity, and not length of description, is paramount. If the denial involves days, units or length of service, specify the days, units or time covered vs. denied.

If more than one service is denied, each service must be identified. In some cases, the services are directly related (e.g., combination therapy) and no essential information will be lost in addressing both services, simultaneously, in Section 5. However, if the services cannot be correctly and clearly defined together, use multiple copies of Section 5.

If the denied item is for a known procedure that can be coded, provide the code.

6. **Additional Information for a Complete Health Plan Case File**

Please attach the requested documents in the order listed in separately marked sections. We recommend that the health plan divide the sections by tabs. If tabs are not available, separate sections with a marked cover page. It is often necessary for CHDR to copy or re-order documents within the case file. Please do not staple or spiral-bind attachments. Ring binders are preferred. Copies may be one or two sided.

The general order for documents within a section is chronological, with the most recent document first ("on top").

Is Disputed Treatment being Offered in the Context of a Clinical Trial?

If the answer to this question yes, the health plan should provide a complete copy of the trial protocol.

Pertinent Section of the Evidence of Coverage and Applicable Riders

Include the pertinent sections of Evidence of Coverage and applicable riders regarding the disputed service.

Internal Determinations and Grievance Notices Sent to the Subscriber

Include any and all forms, call logs, or text documents on which the health plan has recorded its analysis and findings with respect to the denied service, at each stage of adjudication and (internal) appeal. If decision-making was delegated, include documentation of the delegated decision-maker's analysis and findings. Do not duplicate information provided in other sections (e.g., clinical criteria, medical records, etc.). Provide cross-references if you believe they are necessary to ensure CHDR appropriately understands and links documents.

Complete Copies with Attachments of Referral or Claims Forms

Each of these documents is necessary for CHDR to understand the "denial history" of the disputed item or to obtain documentation that specifies the denied service. CHDR does not request or want "claim histories" that are not related to the disputed service. A claim history is "relevant" if that history is cited by an enrollee or the health plan as justification for its position on the disputed service.

Relevant Correspondence from Parties to the Disputed

The health plan must include all correspondence submitted regarding the disputed service. This includes in correspondence submitted by the subscriber, the subscriber's provider or the subscriber's representative.

Medical Records

In general, provide those medical records that a physician would typically expect if the case were referred to her for a decision on the disputed service. Where practical, include actual lab reports, imaging studies, etc. in addition to the professional consultation report.

For *emergency/urgent* cases, include any ambulance notes. For the encounter, include the complete standard emergency room or urgent care record. It is particularly important to include intake or triage notes that may record the patient's first presentation of complaints.

For disputes related to the necessity of *inpatient or long-term care stays*, include admitting notes, history and physical, all consultations, nurses notes, physician orders, and all ancillary evaluations and notes. If the patient has been discharged or proposed for discharge, include the discharge plan and summary.

In some instances, the requirements above may cause health plans to obtain and provide excessive or non-relevant records. The health plan may contact CHDR prior to case submission to discuss available and required records.

Records Requested and Not Available

In this response, the health plan must include a description of the pertinent medical records that the health plan has requested but has been unable to obtain. The health plan must indicate the reasons for unavailability and if the health plan expects to obtain the missing medical records and, if so, within what time frame the health plan expects the missing medical records to be forwarded to CHDR. If necessary, DMHC may subpoena medical records.

Other Relevant Information

The health plan may provide other information it deems relevant to the review.

Inventory of Medical Records Provided by Health Plan, Physician or Enrollee

The health plan must provide a detailed index listing an inventory of medical records provided by the health plan, physician or enrollee.

F. ADDITIONAL INFORMATION REQUEST FROM CHDR

After receiving and reviewing the health plan case file, CHDR staff or reviewers may require additional information. The CHDR Appeal Officer (case manager) will submit additional information requests to the health plan. *The health plan should not receive requests directly from a CHDR reviewer*. In the event that a CHDR reviewer does not follow procedure and contacts the health plan directly, please ask the reviewer to contact CHDR directly and do not provide any other information to the reviewer. In addition, the health plan should notify CHDR immediately.

Requests for additional information are faxed or emailed to the health plan using the *Additional Information* request format (attached). The *Additional Information* request will identify the turnaround time for the health plan response. The turnaround time reflects *delivery* of information to CHDR, as opposed to the mailing date by the health plan. Health plans should respond to information requests for standard cases by mail or hard copy delivery. Expedited or expedited experimental/investigational additional information should generally be faxed (redacted, if possible). Contact CHDR by phone if this is not practical. We recommend that the health plan call CHDR to confirm that faxed material has been received in legible form.

If the health plan does not completely understand CHDR’s additional information request or cannot comply with the request, contact CHDR immediately.